

CERTIFICATION FOR INDUCED ABORTION

Michigan Department of Community Health
Medical Services Administration

Medicaid Payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued and cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- Please TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure, e.g., hospital, anesthesiologist, laboratory for billing purposes.

Patient Name		Patient Medicaid ID No.		Date of Service	
Patient Address (no. & street, etc.)		City		State	ZIP Code
One of these boxes must be checked for payment to be made. By signing below, I certify that:					
<input type="checkbox"/> the life of the mother would be endangered if the pregnancy were continued Please list the medical condition(s) that exist _____ _____ _____					
OR					
<input type="checkbox"/> the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.					
In cases of rape or incest, was a police report filed? (If NO , please explain why not) <input type="checkbox"/> YES <input type="checkbox"/> NO (why not?):					
If appropriate, was a report filed with the local FIA office? (If NO , please explain why not) <input type="checkbox"/> YES <input type="checkbox"/> NO (why not?):					
NOTE: Payment for service is not dependent upon a report being filed with the police or the local FIA office.					
Physician Name (typed or printed)			Handwritten Signature of Physician		
Address					
City	State	ZIP Code	Date Signed	Medicaid Provider ID No.	

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if payment from the Medicaid program is sought.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.